STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152008	A. BUILDING 00 B. WING	08/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED HOSPITAL- INDIANAPOLIS SOUTH	607 S GREENWOOD SPRINGS DR GREENWOOD, IN46143

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S0000	This visit was for two (2) State hospital complaint investigations. Complaint # IN00083475: Substantiated; deficiencies related to the allegations are cited IN00082956: Substantiated; no deficiencies related to the allegations are cited Survey Date: 08/02/11 Facility #: 006218 Surveyors: Linda Dubak, R.N. Public Health Nurse Surveyor Sandra Nolfi, R.N. Public Health Nurse Surveyor QA: claughlin 09/21/11	S0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0322	410 IAC 15-1.4-1(c)(6)(H) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially. Based on policy review, administrative document review and interview, the facility failed to ensure the grievance process was followed for 1 of 5 patients reviewed (#P5). Findings included: 1. The facility policy, "Patient Complaint/Grievance Process", last revised 12/2008, indicated under D. Managing Grievances, Step 4-"...The Hospital CEO/Administrator or designee completes Step 4 of the form: Reviews the findings and actions documented in Steps 1 through 3, and if indicated, document additional actions taken. ...Sends a written response to the complainant within 7 days. ...If resolution is not possible within 7 days, the letter will indicate an anticipated resolution date. A follow-up letter will then be sent	S0322	A review of the Complaint / Grievance process was conducted by the Chief Executive Officer and the Director of Quality and Risk Management in May, 2011. Each step of the process is now being reviewed by the Director of Quality and Risk Management to assure adherence with the existing policy. Letters are being sent to families when appropriate. The results of the oversite reviews are reported to the Quality Council and the Medical Executive Committee on a monthly basis. Since May, 2011 there have been no identified issues with the process. 100% review of all complaints and grievences are now being conducted by the Director of Quality and Risk Management to assure that the policy is followed. Responsible Party: Director of Quality and Risk Management	09/01/2011

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	once the resolution has been achieved." 2. Review of the facility's Patient and Family Complaint/Grievance Report Form evidenced the following: A. A verbal complaint regarding care issues from the family member of patient #P5 on 10/20/10. The report was written by staff member N10 who forwarded it to staff member N2. B. Documentation from the case manager, staff member N10, indicated a meeting with the family member at 1755 on 10/20/10. There was another meeting at 1658 on 10/25/10 that included staff member N3 regarding problems over the week-end. The documentation indicated that staff member N3 assured the family member that he/she would investigate and get back to him/her with answers. C. There was no documentation a follow-up letter was sent once resolution had been achieved, as per policy. 3. At 2:45 PM on 08/02/11, staff members N2 and N5 confirmed they did not send a written response letter to the complainant.			

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S0912	410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v) (a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following: (2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital. Based on policy review, medical record review and interview, the nurse executive failed to ensure cardiac rhythm telemetry was documented for 1 of 5 patients (#P5) in the Special Care Unit (SCU) as required by policy.	S0912	On 2/1/2011, all telemetry technicians and RN staff who work with telemetry were provided education on the policy that addresses telemetry monitoring and the documentation requirements involved in telemetry monitoring. The	09/01/2011

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	Findings included: 1. The facility policy, "Continuous Cardiac Monitoring", last revised 05/2010, indicated "3. Cardiac rhythm will be recorded, interpreted, and documented on the initiation of telemetry monitoring, every four (4) hours thereafter, and more frequently as indicated by the patient's condition." 2. The medical record for patient #P5 indicated the following documentation: A. The patient was monitored with telemetry while in SCU from 6:50 AM on 10/19/10 until 5:45 AM on 10/26/10 when he was transferred back out to the medical/surgical unit. The medical record lacked documentation of any telemetry strips between 1928 on 10/21/10 and 0420 on 10/22/10 and between 1925 on 10/22/10 and 0402 on 10/23/10. There were also no strips between 0803 and 1602 on 10/24/10 and between 0009 and 1031 and between 1215 and 1958 on 10/25/10. The record lacked any documentation to explain the missed every 4 hour monitoring strips. 3. At 11:05 AM on 08/02/11, staff member N1 indicated all patients in the SCU were monitored and strips recorded every 4 hours.		education included the requirement that all telemetry strips must be obtained every four hours and that the strip must be interpreted and authenicated by an RN who is competent in telemetry care. 100% review of all telemetry strips began in February, 2011 by the chief executive officer. The overall compliance rate for four months, from March to June, 2011 was 97%. Random audits have been conducted since June, 2011 and have documented a sustained compliance of 97%. The results of the audits are reported to Quality Council and the Medical Executive Committee on a quarterly basis.Responsible party: Chiel Clinical Officer	

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	4. At 2:30 PM on 08/02/11, staff member N3 indicated all of the patients in SCU were monitored.			